MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

DISCHARGE PLANNING

Effective Date: March 14, 2012 **Policy #:** AD-04

I. PURPOSE: To specify discharge planning procedures to ensure that discharge planning begins at the time of admission and is updated throughout the duration of hospitalization.

II. POLICY: Each person admitted to Montana State Hospital (MSH) will have an individualized aftercare plan specifying services and referrals needed upon discharge. MSH staff will work closely with the patient, the patient's family/significant others and appropriate community agencies to ensure continuity of care is addressed and Montana state statute requirements are met.

III. DEFINITIONS:

A. Community Reentry Plan – A document that provides basic information to begin discharge planning procedures early in the patient's stay.

B. Aftercare Plan – A document that addresses major aspects of a patient's living situation and treatment needs following hospitalization.

C. Discharge Summary – A recapitulation of the patient's hospital course including a summary of the aftercare plan.

IV. RESPONSIBILITIES:

A. Social Worker– the staff member who is assigned primary responsibility for coordinating aftercare planning procedures.

B. Discharge Technician – a position within the Social Work department that assists in the discharge process by ensuring that tasks related to discharge are completed and critical information is tracked and reported.

V. PROCEDURE:

A. COMMUNITY REENTRY PLAN

1. Each patient admitted to MSH will have a Community Reentry Plan developed by that patient's designated Social Worker as soon as practical. The Community Reentry Plan will focus on the individual needs of the patient and will be formulated with the participation of the patient or guardian. Also, participation

will include available family members, significant others and related community agencies.

2. The Community Reentry Plan will be completed on a form developed by MSH (Attachment A) and will identify a community mental health contact person and a MSH Social Worker in order to facilitate communication. The Community Reentry Plan will be faxed to the designated community mental health provider within three days of admission, with a request for response. A description of each contact related to discharge planning will be entered in the patient's medical record.

3. It is recognized that discharge planning will be a ongoing process during a person's hospitalization and that changes are likely to occur in the discharge plan. The discharge plan will be regularly and systematically reviewed by the patient, the Social Worker and treatment team with changes made to reflect the needs and desires of the patient. These changes must be noted in the progress notes.

   When a patient is transferred to another unit or the Social Worker is changed, the new Social Worker should be brought up-to-date at the earliest opportunity by the previous Social Worker.

5. Every effort should be made to involve the community mental health contact person or other aftercare providers in the discharge plan review process. Aftercare providers should be informed whenever significant modifications to a patient's discharge plan are made. This can be done through written, e-mail, fax, or telephone communications.

6. A packet of clinical information will be sent, using the MSH Referral for Aftercare Form (attachment B). The packet shall include:

   a. Social History or Interim History
   b. Most recent Psychiatric Evaluation
   c. Relevant Laboratory results/TB exam
   d. Progress Notes
   e. Nursing Assessment
   f. Recent Physical Examination Summary, including Medical Consultations
   g. Resident Employment evaluation (if completed)
   h. Rehab therapy evaluation
   i. Psychological evaluation (if completed)
   j. Forensic Review Board Report if (if relevant)

   It is the Social Worker’s responsibility to ensure that up-to-date information is sent to aftercare agencies.

7. The Social Work Discharge Process will be followed by the Discharge Technician to facilitate a safe discharge that ensures continuity of care is addressed and Montana State Statute requirements are met.

B. AFTERCARE PLAN

1. Near the end of hospitalization, work pertaining to discharge planning will culminate with the completion of the Aftercare Plan. The Aftercare Plan (Attachment B) serves four functions:

   a. To provide identifying information on the patient that the aftercare provider(s) may find helpful in the provision of services.
   b. To provide specific information regarding the patient's discharge plan; i.e., where the person will live, source of income, medical needs and scheduled appointments.
   c. To provide information that the community mental health program may find helpful in developing a community treatment plan; i.e., major problems, needs, concerns, strengths, and personal goals.
   d. To provide recommendations by MSH staff for aftercare services.

2. The Aftercare Plan is developed through a cooperative effort involving the patient, the MSH Social Worker, the family and significant others of the patient, the community mental health contact person, and other aftercare service providers. The Aftercare Plan will be completed when specific discharge arrangements have been made. Upon its completion, the Aftercare Plan is faxed within 24 hours to the community mental health center contact person and other agencies that will be involved with the patient. The Aftercare Plan is then saved in the Word Proc Final File on the H Drive so Health Information can enter it into patient records. The Aftercare Plan may also be mailed. All applicable HIPPA regulations must be followed when communicating information to aftercare providers or other persons.

C. DISCHARGE INSTRUCTION SHEET

The Discharge Instruction Sheet (Attachment C) will be initiated by licensed nursing staff and completed at the time of discharge. The Social Worker completes the lower portion of this form to indicate scheduled appointments. This document will be provided to the patient, with a copy faxed to the outpatient service provider and a copy placed in the patient’s MSH medical record.

D. DISCHARGE SUMMARY

A discharge summary will be completed by the LIP within 15 days of the patient’s discharge and sent to appropriate aftercare providers (see MSH policy HI-04, Discharge Summary).

VI. REFERENCES: 53-21-180 M.C.A.

VII. COLLABORATED WITH: Medical Director, Hospital Administrator, Social Work Quality Improvement Team.

VIII. RESCISSIONS: #AD-04, *Discharge Planning*, dated November 9, 2009; #AD-04, *Discharge Planning Policy* dated August 28, 2006; #AD-04, *Discharge Planning Policy* dated September 8, 2003; #AD-02, *Discharge Policy*, dated May 15, 2001

IX. DISTRIBUTION: All hospital policy manuals

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per M.C.A. § 307-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Associate Hospital Administrator

XII. ATTACHMENTS:

A. Initial Treatment Plan & Community Reentry Plan
B. Montana State Hospital Referral for Aftercare
C. MSH Aftercare Plan
D. Discharge Instruction Sheet

_____/___/__ _____/___/__
John W. Glueckert Date Thomas Gray, MD Date
Hospital Administrator Medical Director

_____/___/___
Joan Daly, LCPC
Associate Hospital Administrator

MONTANA STATE HOSPITAL
INITIAL TREATMENT PLAN

Document/describe problems to be addressed and corresponding goals. Suggestions below are guidelines only, not complete lists.

Date	Immediate Problem	Short Term Objective	Intervention	Date Resolved

1. Risk to self
A. Tolerate distress safely
B. Improved coping skills
*****C. Participate in further assessment
☐ Suicide/Self-harming
☐ ULP

2. Risk to others
A. Interact safely and appropriately with others
B. Demonstrate willingness for redirection
C. Express anger in an acceptable manner
***** D. Participate in further assessment
☐ Aggression/Violence

3. Inability to care for self
A. Improved eating patterns
B. Improved sleep patterns
C. Improved hygiene
D. Improved toileting
E. Improve skin integrity

4. Impaired coping skills
A. Learn about distress tolerance
B. Actively participate in unit activities
C. Develop a recovery plan
***** D. Participate in further assessment
☐ Trauma History/Sexual Behaviors
☐ Co-Occurring History

5. Altered thought process
A. Engage in behaviors which promote stability/discharge
B. Improve medication knowledge and benefits
C. Improve mood stability
D. Improve orientation to time, place, and person

6. Medical problems
A. Physiologic stability (CIWA, CINA)
B. Tolerate medications
C. Safe mobility
D. Pain control allows for ADL's
***** E. Participate in further assessment
☐ Nicotine dependence
☐ Other medical complications *****

Check appropriate Risk Precaution below and flag unit board. **Admit Status** (indicate change in status by date)

Risk Precautions

Status

_____Emergency Detention
_____Court Ordered Detention
_____Voluntary
_____Involuntary
_____Vol –D
_____ COE
_____ UTP
_____ GBMI
_____ NGMI
_____ Tribal

☐ Suicide/Self Abuse (S)
☐ ULP
☐ Aggression/Violence (A)
☐ Sexual Behaviors (X)
☐ Fire Safety (F)
☐ Substance Use Disorder (M1)
☐ Falls (M2)
☐ Seizures (M3)
☐ Medical (M4)

_____ Unit Restricted
_____ Escort Off Unit
_____Pending Legal Process
_____Other

Signatures

Signature _____ Date/Time _____Signature _____ Date/Time _____

Signature _____ Date/Time _____Signature _____ Date/Time _____

Signature _____ Date/Time _____Signature _____ Date/Time _____

Patient Signature _____ Date/Time _____

NAME: _____ HOSPITAL NUMBER: _____ Unit Placement _____

MONTANA STATE HOSPITAL
COMMUNITY REENTRY PLAN

NAME: _____ **HOSPITAL NUMBER:** _____ **Unit Placement** _____

Admission Date: _____ Commitment Status: _____ Estimated Discharge Date: _____

Diagnosis: _____

Social Worker: _____ Phone Number: _____ Fax Number: _____

Mental Health Services prior to admission: _____

_____

Discharge Criteria: _____

Plan: _____

Person's interest in returning to community: _____

FUNDING

☐ MHSP Eligibility Dates _____ to _____

☐ Medicaid ☐ Medicare ☐ VA ☐ Private Pay/Other ☐ Funding Pending _____ ☐ No Known Funding

Family/Friends/Advocates: _____

Other Comments: _____

Referred to: _____ Social Worker Signature: _____ Date/Time: _____

Initial Discharge/Aftercare Plan & Admission Document Faxed to # _____ Date Faxed: _____

To be completed by community provider:

Recommended Aftercare

☐ NO, reason: _____

☐ YES, for what services: _____

☐ Maybe, other needs: _____

☐ Group Home	☐ Case Management	☐ Medication Follow Up	☐ Nursing Home
☐ Adult Foster Care	☐ Day Treatment	☐ Transitional Care	☐ Intensive Group Home
☐ PACT	☐ DD Services	☐ Depo Meds	☐ Other _____
☐ CLO	☐ Individual Therapy	☐ Chemical Dependency Tx	

Provider Signature: _____ Date Faxed to MSH: _____

MONTANA STATE HOSPITAL
REFERRAL FOR AFTERCARE

Date: _____

Aftercare Provider: _____

Provider Address: _____

Patient Name: _____ Unit: _____

Social Worker: _____ Phone #: 693-_____

Funding:

☐ MHSP

Eligibility dates _____ to_____.

☐ Medicaid

☐ Private Pay

Services Requested:

☐ Group Home
☐ Adult Foster Care
☐ PACT
☐ Case Management
☐ Day Treatment
☐ Medication Follow-up

Estimated length of time to discharge:_____.

To be completed by the Community Provider:

Date of review: To be completed by the Community Provider:

Date of review: _____

Accepted for Services: Yes ☐ No ☐

If not accepted, barriers to acceptance: _____

_____

_____

_____

Comments: _____

_____

_____

MONTANA STATE HOSPITAL
AFTERCARE PLAN

NAME: **DATE:**

HOSPITAL #: **D.O.B.:**

TYPE OF COMMITMENT:

COUNTY OF ADMISSION: **ADM. DATE:**

DIAGNOSIS: **Axis I:**
Axis II:
Axis III:
Axis IV:
Axis V:

TYPE OF RELEASE: **DISCHARGE DATE:**

NAME AND ADDRESS OF INTERESTED RELATIVE/FRIEND:

Phone:

DISCHARGE ADDRESS/LIVING ARRANGEMENTS:

Phone:

DISCHARGE ARRANGEMENTS THAT HAVE BEEN MADE:

Travel Arrangements:
Follow-up Appointments:
Other Community Contacts:

MAJOR PROBLEMS/NEEDS/CONCERNS:

PATIENT'S PERSONAL GOALS:

PRESENT FINANCIAL NEEDS AND SOURCE OF INCOME:

NAME AND ADDRESS OF REP. PAYEE: **PHONE:**

AFTERCARE SERVICES RECOMMENDED BY MONTANA STATE HOSPITAL:

___Psychiatric/Medication Follow-up ___Case Management ___Therapy ___Day Treatment

___PACT Team Services ___Group Home Placement ___Adult Foster Care Placement

___In-patient CD Treatment [3.5 Level] ___Residential CD Treatment [3.1 Level]

___Intensive Out-Patient CD Treatment ___Out-Patient CD Treatment

PATIENT'S MEDICAL NEEDS:

PRESENT MEDICATIONS:

MEDICATION TO BE SUPPLIED BY MSH UPON DISCHARGE:

MEDICATIONS WILL NEED TO BE RENEWED BY (DATE):

REPORTS ENCLOSED WITH AFTERCARE PLAN:

_____ Social History
_____ Psychiatric Evaluation
_____ Psychological
_____ Dr. Orders
_____ History & Physical
_____ Treatment Plan
_____ Other:

_____ Nursing Assessment
_____ Lab Results/RB exam
_____ Progress Notes
_____ Rehabilitation Therapy Evaluation
_____ Current Commitment Papers

REFERRED BY:

SENT TO:

Montana State Hospital
Warm Springs, Montana 59756
(406) 693-

ATTENDING LIP: _____

MONTANA STATE HOSPITAL
DISCHARGE/HOME VISIT INSTRUCTIONS

NAME:_____ DATE OF DISCHARGE/H.V.: _____

MEDICATIONS

MEDICATION NAME	DOSE	TIME/ INSTRUCTIONS	INFO HANDOUT	
			YES	NO

☐ Instructed on taking medication(s): verbalizes an/or demonstrates understanding
Medication provided: ☐ 2 weeks supply ☐ Other _____
Diet ☐ Regular ☐ Other _____ ☐ Handout Given

Discharge/Home Visit Arrangements: _____

Other Instructions: **No alcohol or illegal drug use. No access to firearms or ammunition.**

REFERRALS & APPOINTMENTS

Name	Address	Phone	Date	Time

Fax to: _____ Fax #: _____

	/	/
Social Worker's Name	Patient's Signature Date	Nurse's Signature Date
Fax to Community Provider	Original: Health Information	Copy: Patient

MEDICATION INSTRUCTIONS

1. Learn the name of the medication and the reasons why you are taking the medication.

2. Take the medication at the times and in the amount prescribed.

3. Do not offer your medication to anyone else. It has been especially prescribed for you and may be harmful to someone else.

4. Keep all medications securely away from the reach of children.

5. Certain medications become outdated, at which time they may be ineffective or even harmful. If your medication is more than several months old, ask your pharmacist if it is safe and effective.

6. Do not mix medications in one container. Keep each medication in its own container.

7. Alcohol should be avoided when taking medication.

8. Medicine may produce an allergic or unanticipated reaction, even in people who are not known to be allergic or who have taken the drug before. Contact your physician if you experience rash, fever, vomiting, diarrhea, or other unusual symptoms.